TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, April 12, 1893.

The President, ARPAD G. GERSTER, M.D., in the Chair.

OLD UNUNITED INTRACAPSULAR FRACTURE OF NECK OF FEMUR TREATED BY NAIL FIXATION.

Dr. WILLY MEYER presented a man, thirty-nine years of age, who when seen in November, 1892, gave a history of having fallen ten months before from a height of sixteen feet, and had since been an invalid. On examination, the left leg was found much shorter than the right, turned outward, and as he stood on crutches he could not, without making special effort, touch the floor with his toes. On placing him upon a table it was not difficult to make out that there was an intracapsular fracture of the femur. There were all the symptoms; the leg was turned outward, the trochanter was high, 3½ inches above Roser-Nélaton's line, and on making rotation it was readily perceived with the fingers on each trochanter that the radius of the circle was shorter than on the right side. On making traction it was easy to bring the thigh further down, and with the finger under the trochanter slight crepitation could be felt. The patient was unable to stand on this limb, and as he was comparatively young, and had fallen perpendicularly upon his feet, showing that, if the rule were followed, the fracture was intracapsular, it was decided to operate.

Mechanical and expectant treatment was deemed inexpedient on account of the poverty of the patient. Which one of two procedures should be adopted was to be decided after opening the hip joint. If it were found that the head was probably still able to produce enough new bone, that means if it should bleed when scraped, it was intended to bring the two fragments together, and this was done; but had the head not bled when freshened the neck would have been resected and brought into the acetabulum. The operation was per-

formed on December 3, 1892, the hip joint being opened by the ordinary Langenbeck incision. The two fragments were found held together by loose connective tissue, and when this was cut away the interesting condition was observed that the fracture had taken place just at the base of the head, so that the smooth head was still perfectly movable in the acetabulum. The neck was atrophied and, as it appeared, put on the shaft in a slightly smaller angle, but otherwise it was in perfect condition. The annoying feature of the operation was that while the fractured surface of the head showed a concavity, the other side did not show a corresponding convexity, but also a concavity. After having removed the adhering tissue the head was scraped until its entire surface bled. The neck end was shaped with the chisel to correspond to the concavity of the head, having first stripped back the periosteum. The fragments were now fastened together by two long nails, such as have been recommended by Wyeth in resections of the knee joint.

The bone was soft, and the nails were inserted with perfect ease, but on removing the handle the first nail broke just at the surface of the bone, so that it held the fragments in apposition. The second one also broke, not at the surface, but inside the bone, and it was necessary to chisel out a piece of the bone to get at the broken end. This is mentioned because of its bearing on the after-history. The wound was partly closed with stitches, a gauze drain was introduced, and an extension splint applied to which fifteen pounds weight was attached. The next day it became evident that during the night a parenchymatous hæmorrhage had taken place from the porous bone; the pulse was 130 and the patient was very restless. Besides proper stimulation, hypodermoclysis of 800 ccm. of salt solution was at once made into the abdomen, but as a few hours afterward the patient's condition had not improved, intravenous transfusion of one quart of physiological salt solution was made. After this the heart began to beat better, the patient rallied and went on to complete recovery. He was in bed with splints full ten weeks, traction being made eight weeks. When he first got up to walk he used crutches; now he uses one cane. The shortening before the operation was three inches and a quarter; now it is an inch and a half. Perfect bony union has apparently taken place between the fragments. The movements are only slightly restricted, but otherwise normal. The limb having been out of use for ten months before the operation, there was of course considerable muscular atrophy.

Dr. LANGE remarked that the functional result in this case was certainly very good, although he did not consider that proved that osseous union of the neck had taken place. Indeed, he might say that he was inclined to think osseous union was not perfect, but that there was reliable fibrous union holding the fragments in good apposition. He thought one could feel on traction a certain amount of yielding of the neck of the femur. Then, too, the amount of shortening still present was too great to be accounted for in any other way than by assuming that there was a certain distance between the two fragments. Dr. Lange had under observation a young lady, twenty-one years of age, who received a fracture of the neck of the femur twelve years ago. In her case there had been gradual increase in the shortening of the limb. The shaft of the femur was freely movable on the os ilium, but the function of the leg was so good that she walked without a noticeably high shoe and danced, but to walk long distances tired her. She was so clever in elevating the other side of the pelvis in walking, and thus preventing exaggerated lameness, that one would not suppose she was laboring under so great mechanical difficulties. The result in Dr. Meyer's case certainly justified the procedure to which he resorted.

Dr. MEYER thought the amount of shortening could be accounted for by the amount of bone which he had been compelled to remove from the fragments when uniting them, and by the slight change of the axis of the fragments which had been made necessary in order to secure close approximation; also, perhaps, by the changed angle between neck and shaft. Thus far he had looked upon the case, and did look at it yet, as one of osseous union.

STRANGULATED GANGRENOUS LITTRE'S HERNIA; LAPAROTOMY; LONGITUDINAL ENTERORRHAPHY; RECOVERY.

Dr. MEYER presented a woman, sixty-nine years of age, who was brought to the hospital late in the evening of the fifth of February, having been sent there for incarcerated hernia which had existed for six days, the physician sending her remarking that perhaps immediate operation might still save her life. When first seen she was lying in bed, and her appearance was not that of one having strangulated hernia of six days' duration. On being questioned, she

said that she had not passed gas the first five days, but on the trip to the hospital she had passed much gas. The abdomen was not especially painful, but in the right groin there was a swelling looking like a femoral omental hernia, its pedicle apparently extending up into the abdomen. It was doubtful whether this was really omentum, and the condition was explained by supposing that there had been an inflammatory condition in the hernial sac, and that perhaps there was a pro-peritoneal fatty growth, but not strangulated hernia. The patient having passed a large amount of gas, an operation was not undertaken. The patient was not seen again for a few days. She had had, with the help of an enema, a movement every day, had passed gas and had taken food quite well. Still, on the fifth day after her entrance into the hospital she complained of some more pain, and as the temperature showed a slight rise it was decided to operate.

The operation was performed on the 11th of February. A longitudinal incision was made, cutting down on a pro-peritoneal, fatty growth, when an odor of gangrene was noticed. The sac, which seemed to be very small, could not be entered. Perforation of the gut was not evident. Being unable to get at a proper diagnosis from this side, laparotomy was done at a higher point. The gut at this point was normal. After putting in flat sponges and gauze the region of the hernia was opened up, and it was found that the edge of a small knuckle of intestine had been strangulated and become gangrenous. The mesentery was still in the abdominal cavity, and only the convexity of the coil had been incarcerated. It was a true Littre's hernia. Lifting up the knuckle and finding it gangrenous, the operation described by Dr. Abbe last year was decided on. That is, the slough was surrounded by a longitudinal incision, then the incision was lengthened parallel with the long axis of the cut, forming a longitudinal wound. The two ends were then turned to each other in the shape of an elbow and fastened together with a double row of sutures. The abdominal wound was left open. Healing went along nicely; no liquid ever escaped, the patient soon passed gas and had movements of the bowel. She is now perfectly well.

Dr. Meyer then showed a specimen from a similar but less fortunate case. The patient had a fæcal fistula for a long time after an operation for, as far as he could make out, a gangrenous Littre's hernia of the sigmoid flexure. As the fistula would not heal, lap-

arotomy was performed. The fistulous gut was lifted out of its bed and the operation which has just been described was performed. The abdominal wound was partly closed with silk and partly with silkworm gut for secondary sutures. The silk was evidently not thoroughly aseptic, for where the silk sutures passed through the abdominal walls suppuration set in, and the patient died of peritonitis on the third day. Where silkworm gut had been used no suppuration had taken place. The specimen shows the manner of incision and the folds formed within the cut. The so often observed repetition of similar cases within a short period was shown by another case of gangrenous Littre's hernia entering the hospital soon after the patient just presented.

Dr. ABBE said he thought this method of operating applicable to such cases as the speaker had described, and also to those like the one in which he had applied it, a knuckle of the gut being caught under the ring and gangrene having taken place about three-quarters of an inch along the transverse axis of the gut. In that instance he cut through the gangrenous portion by an incision on each side of it extending above and below a distance of about an inch and a half, then brought the two edges together, getting immediate restoration. He considers that this method would be available in many cases where resection would be too severe an operation.

NEPHRECTOMY WITH RESECTION OF TWO RIBS.

Dr. LANGE presented a woman from whom he had removed the left kidney, the specimen having been presented at a previous meeting, to show the incision he had found suitable for this individual case. As in many women, the lower portion of the thorax was narrow and the last rib directed almost directly downward. The kidney was considerably enlarged in an upward direction under the diaphragm. To get sufficient access he added a cross incision to the usual lumbar incision at its upper point. This allowed of excision of the last two ribs, and widened considerably the lower aperture of the thorax.

He thought that dogmatic rules about which incision should be chosen should not be laid down. The size, and especially the position of the organ, also the nature of the disease, made one or the other incision more preferable for the given case. It should be the rule to make everything as accessible as possible, and to work as little as possible in uncertainty and darkness.

In the present case the wound had been freely contaminated with pus during the operation. It was left entirely open and tamponaded. With secondary suture recovery took place in a comparatively short time.

NEPHRECTOMY FOR ADENO-CARCINOMA OF LEFT KIDNEY; RECOVERY.

Dr. LANGE also presented a man, thirty-nine years of age, healthy and robust up to August, 1892, when he commenced to suffer from attacks of pain in the left loin, the pain radiating toward the region of the pubes. In the beginning of December he commenced to pass bloody urine, and frequently lost blood in large quantities. Says he lost 22 pounds within two months. When he came under observation in the beginning of February, no tumor could be detected. The cystoscope revealed the escape of blood from the left ureter, while from the right side clear urine escaped. There was some dulness over the lower part of the left thorax, but it remained uncertain whether that was due to enlarged spleen. No elements of tumor were found in the urine.

On February 9 nephrectomy was performed. The tumor had taken its origin from the upper pole of the kidney, and had grown upward under the diaphragm. In spite of removal of the last rib its enucleation was very difficult and tedious, because it was necessary to work under the diaphragm through a comparatively narrow pass. Many tight adhesions existed, and the plan to remove the organ, including its thick capsule, had to be given up. The capsule had to be opened, and the mass enucleated as rapidly as possible. A large portion of the already loosened capsule was then removed. After-treatment with gauze tamponade. Secondary suture and undisturbed convalescence. The hæmorrhages with the urine have ceased and the patient has gained a good deal since the operation. The chances for permanent recovery are, of course, not hopeful, owing to the nature of the growth. The tumor was about the size of a small child's head, and rather soft, succulent, and abundantly supplied with blood. It occupied the upper third of the renal substance, with small remnants of kidney tissue scattered within its mass. In several places a softening process had evidently taken place, giving rise to cyst-like spaces.

Microscopical examination shows epithelial elements in tubular arrangement. The observation made by others that an adenomatous character is peculiar to cancerous tumors of the kidney seems also to hold for this case.

PYLORECTOMY FOR CARCINOMA; RECOVERY.

Dr. LANGE then presented a third patient, a woman, forty-two years of age, who had lost one sister from cancer of the stomach, and who, after rapidly failing in health for some months, developed symptoms of pyloric stenosis. On examination a large tumor could be felt in the region of the pylorus; the stomach was dilated and dislocated downward. On March 1 last laparotomy was done with the view of doing gastroenterostomy. It was found that the tumor was large but movable, and could be detached from the mesocolon. Resection was, therefore, performed, and a large portion of the stomach was removed. The cut through the stomach had to be narrowed to about one-third of its size to make it correspond to the size of the duodenum. Internal mucosa suture with catgut; two external rows of suture with fine silk; iodoform tampon.

The patient made an uninterrupted and smooth recovery, and has gained considerably in weight, health and appearance, and does not have the slightest digestive trouble. The final outlook is, of course, not hopeful, and the disease will most likely recur. Still, the patient is apt to live longer than after a gastroenterostomy.

PYLOROPLASTY FOR CICATRICIAL CONTRACTION OF THE PYLORUS; RECOVERY.

Dr. LANGE also presented a man, forty-two years of age, who first experienced pain in the stomach and at times in his back about three years ago. It came on periodically and was sometimes very severe. The intervals were sometimes several weeks long. In spite of various methods of treatment no lasting relief was secured, and the patient gradually became weaker and lost flesh. He was reduced from 155 to 105 pounds. During the attacks of pain he frequently had spells of nausea and vomiting, and sleep was so much disturbed that night after night he paced up and down in his room.

This continued for about two and a half years. He finally con-

sulted Dr. Linsmore, who called in Dr. Eischorn, and the conclusion was reached that stenosis of the stomach existed. The history, the presence of hydrochloric acid in excess, the absence of a noticeable tumor, pointed to its benign nature. On February 22 pyloroplasty was performed. The operation was tedious on account of adhesions and the fixation of the pylorus against the vertebral column. The scar tissue was so hard and thick that the needle could be passed through only with difficulty.

The patient made an excellent recovery, and has gained in weight. His digestive trouble has promptly disappeared since the operation, and any kind of food is well digested. Several times colicky pains have set in, which Dr. Eischorn thought might be due to the excess of acid, and which have disappeared since he was put on alkalines.

This is the third case in which Dr. Lange has done pyloroplasty for benign stricture in the pylorus or duodenum. All have ended in recovery, and the results have been very prompt and satisfactory.

RELIEF OF ŒSOPHAGEAL STRICTURE BY A "STRING SAW."

Dr. ROBERT ABBE presented a young woman on whom he had operated four months ago for impermeable stricture of the œsophagus. For the history of this case, and the method of operating adopted in it, see ANNALS OF SURGERY, April, 1893, p. 489. Dr. Abbe's object in presenting the patient was to show that the stricture had remained patent, there having been no perceptible degree of recontraction. The same sized bougie passed which was employed at the time of the previous report. Solid food, as well as liquid, was swallowed without difficulty. The patient continued to pass a bougie every other day, to avoid the possibility of recontraction taking place.

Dr. LANGE, in discussing Dr. Abbe's case, said that a somewhat analogous case came under his observation in which he cut the stricture from below by a graded series of small blades made especially for the case. So far as the tendency to recontraction is concerned, the act of deglutition, especially the swallowing of solid food, must do something to prevent it. His case occurred in a child two years of age, which had swallowed some lye and burnt the œsophagus extensively, causing much contraction. Since the operation one can still

feel some portion of the stricture, yet there is no tendency to recontraction, the operation having been done three or four years ago. A bougie is passed every one or two months. The child is well able to swallow solid food. It may be, however, that the injured part will not grow with the growth of the child, which would result in some seeming relative contraction of this part. Dr. Sands once reported a case which illustrated this peculiar lack of tendency to recontraction after operation.

SALIVARY CALCULI.

Dr. JOHN A. WYETH showed several calculi removed from Steno's duct, four or five being the size of buckshot, two or three somewhat larger. They were removed from the right side in a girl of four or five years, who had been supposed to have lymphangiectasis, for which she had been submitted to two or three operations. When he cut into the tumor the calculi were felt, and after they were removed the girl made a complete recovery. It is now about nine months since the operation, and the saliva flows on that side normally.

Dr. A. G. GERSTER was reminded by Dr. Wyeth's case of calculi of the parotid gland of one of calculus of the Whartonian duct operated upon by him last summer. There was fever attending a swelling in the submaxillary region on one side, the soft tissues at the floor of the mouth being considerably swollen, the tongue protruding, saliva escaping from the angles of the mouth. A certain portion of the swelling corresponding to the submaxillary gland was very tender on pressure. The patient was anæsthetized, an incision was made down on the gland, when a quantity of turbid serum, resembling pus, escaped from the organ. The irritation and fever subsided after this operation, but the wound would not heal, and the patient continued to complain of pain at the bottom of the wound. Several weeks after the first incision had been made, Dr. Lilienthal, his assistant, felt, on examination through the oral cavity, a hard mass in the Whartonian duct under the oral mucous membrane. An incision was made upon this, and a calculus about the size of a pea was extracted. The wounds then healed promptly. In this instance the calculus had not only obstructed the flow from the submaxillary gland, but had set up inflammatory swelling as well, with fever and pain.